History and Context

For a review of the history and purpose of these reports, the reader is referred to the "New TDO Exception Reporting Data Overview" document dated January 2015, which is available on the Department of Behavioral Health and Developmental Services (DBHDS) website at the following link: www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data. Previous monthly reports can also be located on this page.

This document is the ninth monthly report of data[1] collected from Community Services Boards (CSBs) and regions[2] for fiscal year 2015 (FY 2015). The following sections contain the summaries and graphs of the monthly data reported to DBHDS through March 2015. For the current report month, March 2015, there were an average of 1,604 emergency contacts received by CSBs, 235 emergency evaluations completed and 71 TDOs issued and executed each day across the Commonwealth. These figures are a substantial increase over the February counts of these events, and are the highest monthly totals for these data elements for the FY 2015 year to date. In this report, the total counts of events are presented for each month and for the fiscal year to date for ease of comparison and trend analysis.[3]

Additionally, certain high risk events are reported separately by CSBs, on a case-by-case basis as they occur. These involve individuals who are evaluated and need temporary detention, but do not receive that intervention. There were ten such events in the March 2015 reporting period. Each of these events triggers submission of an incident report to the DBHDS Quality Oversight Team [4] within 24 hours of the event. The reports describe the incident as well as initial actions to resolve the event and prevent such occurrences in the future. In each case, DBHDS Quality Oversight Team reviews the incident report and actions of the CSB for comprehensiveness and sufficiency, and responds accordingly if additional follow up is needed. CSBs continue to update DBHDS until the situation has resolved and follow up is completed.

Of the nine events reported in March, four involved individuals who were in emergency custody when evaluated, and five involved individuals who were evaluated voluntarily (i.e., they were not under an ECO). Of the nine events, five involved individuals who eloped from the evaluation site before the TDO was executed. Seven of these cases ultimately resulted in the individual's hospitalization, and in two cases the CSB was not able to establish any ongoing treatment relationship with the individual after exhausting all options to do so. Additional detail on each of these cases can be found in Appendix D, page 21.

[1] See Appendix A for complete detailed listing of these definitions.

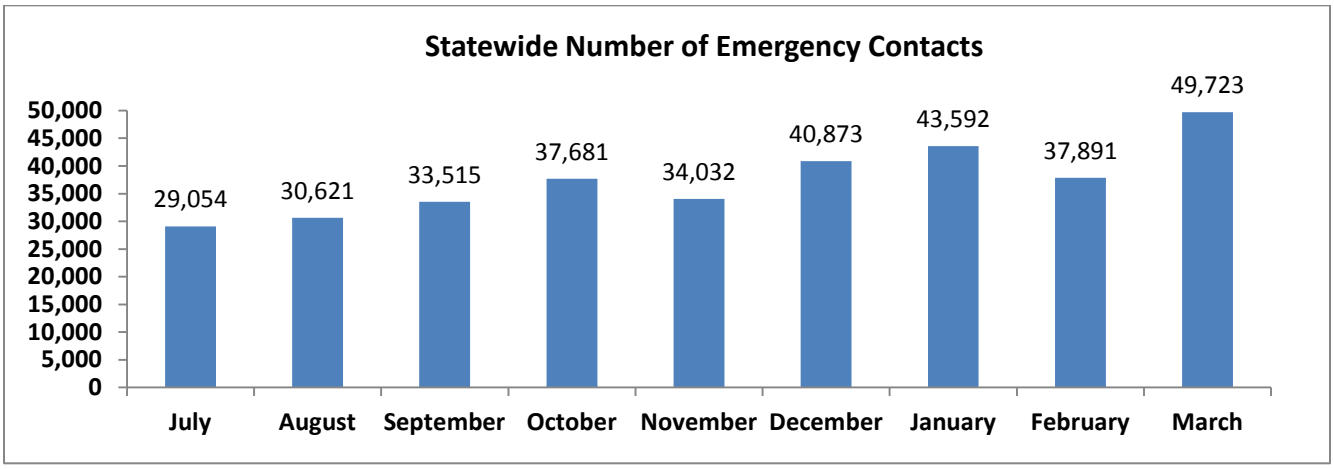
[2] There are 39 Community Services Boards and 1 Behavioral Health Authority in the Commonwealth, referred to in this report as CSBs. See Appendix B for a complete listing of CSBs within each of the seven regions.

[3] In addition, data is reported both statewide and by region in the report and in Appendix C.

[4] The Quality Oversight Team includes the DBHDS Medical Director, Assistant Commissioner for Behavioral Health, Director of Community Behavioral Health Services, Director of Mental Health, and MH Crisis Specialist.

Graph 1. Emergency contacts statewide

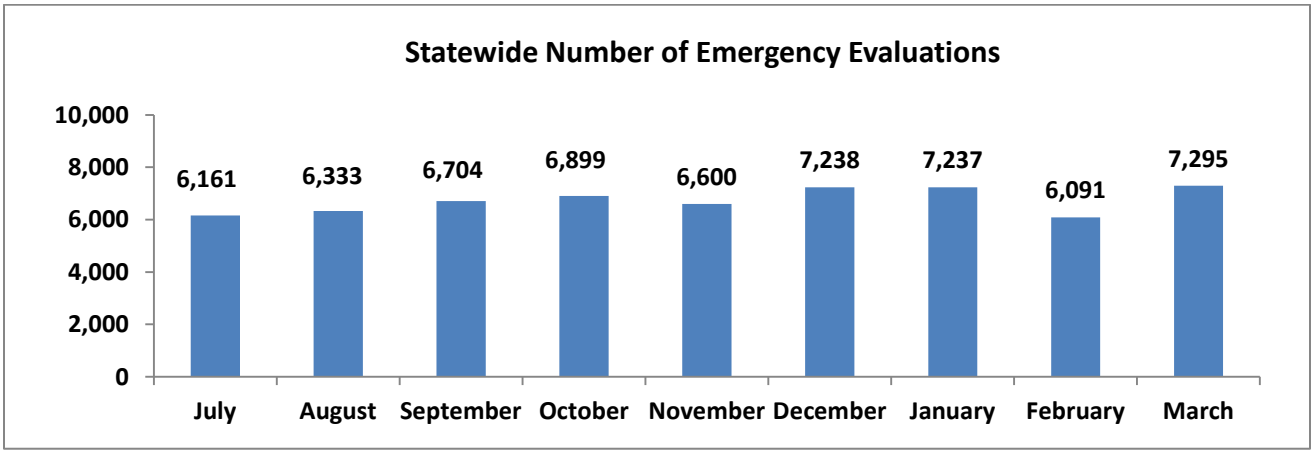
Emergency contacts are events requiring any type of CSB emergency service involvement or intervention. There were 49,723 emergency contacts reported statewide during the month of March, 2015, which is a 31% increase from February 2015. Notwithstanding November and February, this continues a general trend upward since July, 2014, as shown in Graph 1, below. Regional data is displayed in graph 1a and table 1 in Appendix C, page 12. All regions reported increases over February in the number of contacts, with Regions 1 and 5 reporting the most significant increases, 39% and 42% respectively. Of the other regions, Region 3 reported a 34% increase from February, Region 2 a 23% increase, Region 6 a 27% increase, Region 4 a 19% increase and Region 7 a 14% increase. DBHDS initiated specific inquiries to all CSBs to better understand the causes of these fluctuations in their respective regions, but to date, no CSBs or regions have been able to identify any specific local events, agency actions or system changes that have directly influenced the volume of emergency contacts. As stated in previous reports, refinements in data gathering procedures at the local level combined with clarification of data definitions by DBHDS in November 2014 may account for some variability in these numbers.



Graph 2. Emergency evaluations statewide

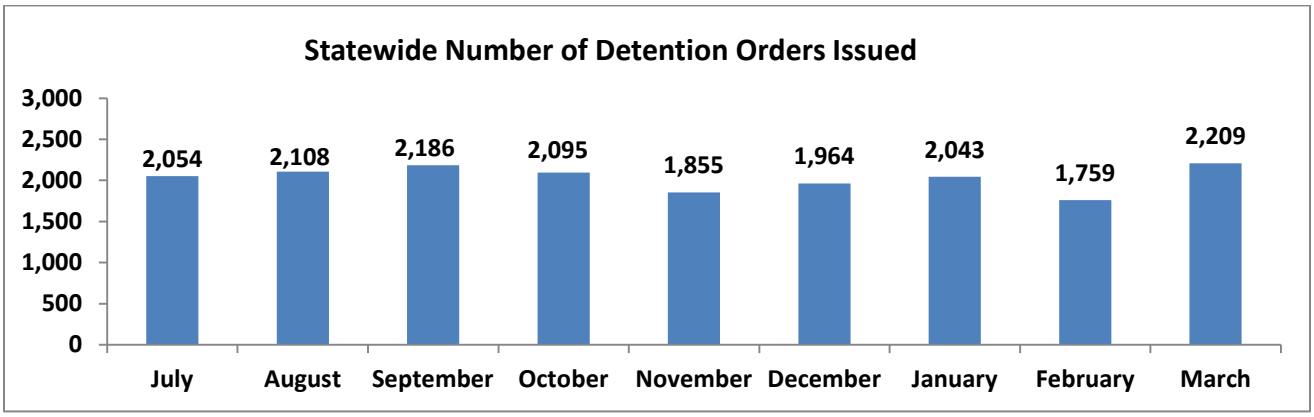
Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. The number of emergency evaluations reported statewide in March was 7,295, which is a 20% increase from February, and the highest month of the fiscal year to date. Region 2 was the only region reporting a decrease of 3%. All other regions reported increases in evaluations, but of note, Region 7 reported a 67% increase. When compared with February, evaluations in Region 3 increased by 40%, Region 5 increased by 34%, Region 4 increased by 23%, Region 1 increased by 15% and Region 6 increased by 3%. Regional data is displayed in graph 2a and table 2 in Appendix C, page 13. The figures for emergency contacts, emergency evaluations, and TDOs that are reported in subsequent pages of this report may represent duplicated (i.e., not mutually exclusive) counts of individuals because an individual may have made contact, or been evaluated or

detained, on more than one occasion and could therefore be included two or more times in any of these categories.



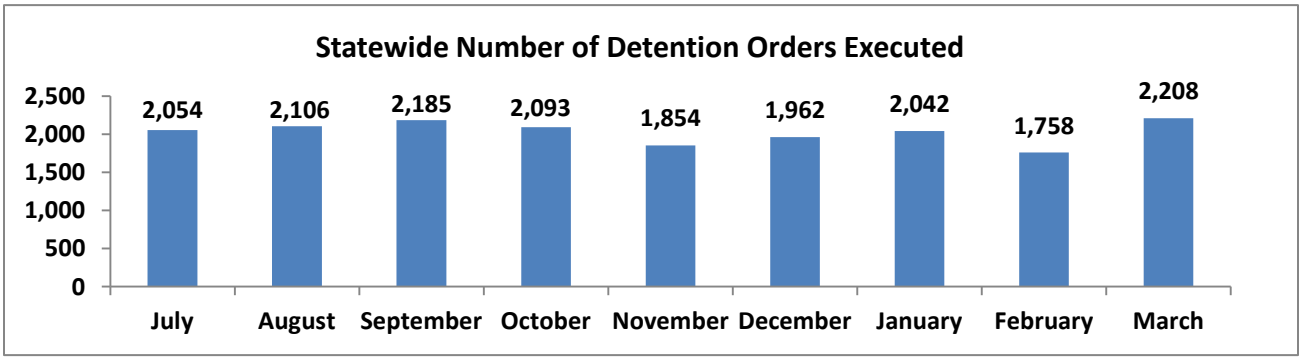
Graph 3. TDOs issued statewide

A TDO is issued by a magistrate after considering the findings of the CSB evaluation and other relevant evidence, and determining that the person meets the criteria for temporary detention under § 37.2-809 or § 16.1-340.1. A TDO is executed when the individual is taken into custody by the officer serving the order. In March, there were 2,209 TDOs issued (Graph 3), and 2,208 TDOs executed (Graph 4).These are the highest monthly figures for FY 2015, and all regions except Region 7 reported higher numbers from February. Region 7 experienced a 6% decrease. Region 2 experienced the smallest increase with a 3% increase while Region 5 increased the most with a 51% increase in TDOs issued in March. Region 3 increased by 38%, Region 6 increased by 28% and Region 4 by 22%. Graph 3a and table 3 (page 14) and graph 4a and table 4 (page 15), display this data reported by region in Appendix C. This is an increase of 450 TDOs issued from February, 2015, representing an increase of approximately 26% statewide. **About 70% of the emergency evaluations reported in March (5,087 of 7,295) did not result in a TDO.**



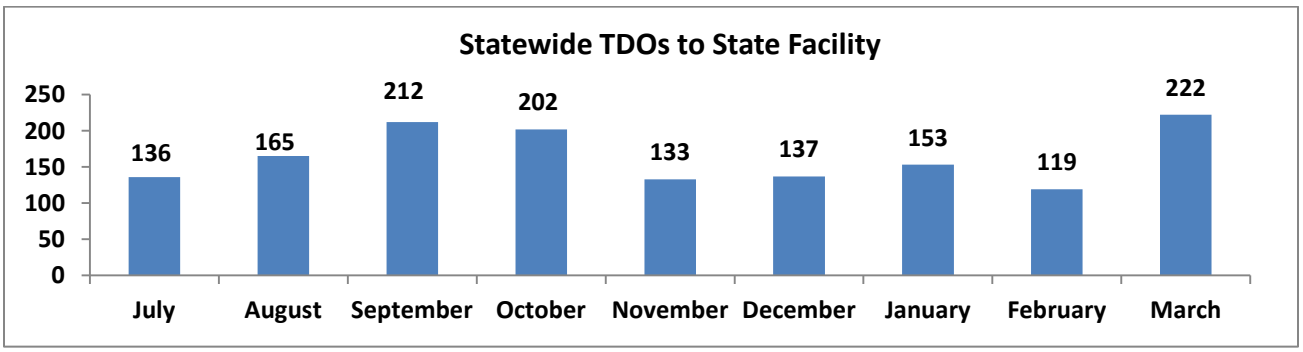
Graph 4. TDOs executed statewide

There was one temporary detention order issued but not executed during the month of March. The individual was assessed in a local emergency department and was found to meet TDO criteria. After the TDO was issued, the emergency physician determined the individual's medical needs were urgent and when the individual refused care, a Medical TDO was obtained by the physician. After being medically treated, the individual was re-evaluated and no longer met criteria for a TDO.



Graph 5. TDO admissions to a state hospital statewide

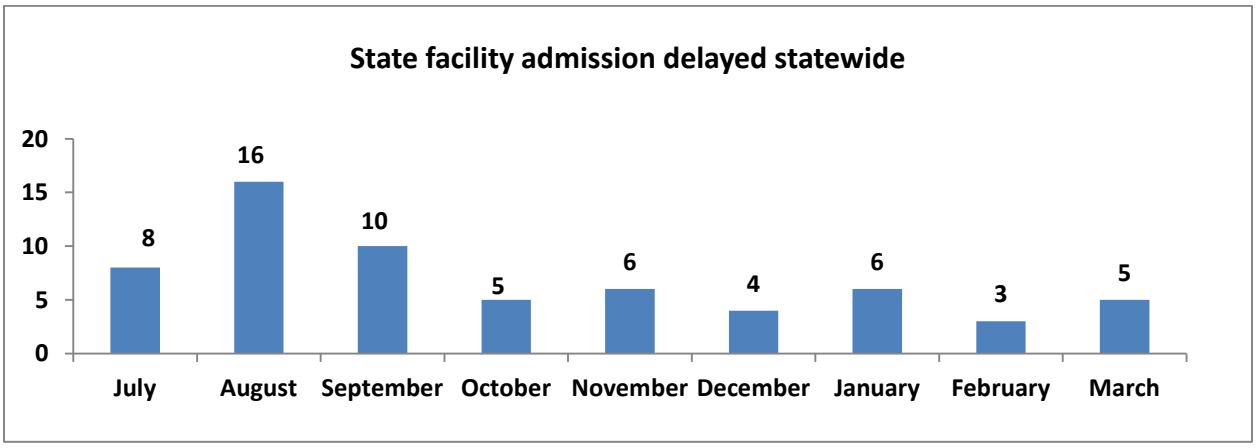
Of the 2,208 TDOs executed in March, 222 (10%) resulted in admission to a state hospital [5] (Graph 5), representing an increase of 87% from February. This is the highest monthly figure for this data element reported to date in FY 2015. All regions reported increases of over 30%. However, regions 1 and 6 reported the most significant increases of 246% and 189%, respectively. The remaining regions reported increases ranging from 33% (Region 7), to 81%, (Region 5). There continues to be variance among regions in the number of state hospital TDO admissions, as shown in Graph 5a and table 5 in Appendix C, page 16. This variance reflects both recognized seasonal trends and each region's unique resources, protocols, and access to community psychiatric facilities. DBHDS is working with regions to minimize the use of state facilities for temporary detention through increased use of community psychiatric resources, alternatives to hospitalization, and more explicit utilization protocols for state hospitals. These strategies have largely been effective in reducing and managing state hospital TDO admissions since October. DBHDS also closely monitors use of the Psychiatric Bed Registry.



[5] Source: DBHDS AVATAR admitting CSB data

Graph 6. State hospital admission delayed statewide

In March, there were five occasions when the state hospital was deemed the "hospital of last resort" but admission could not be accomplished before the ECO time period expired (Graph 6). The delays in two of these cases were due to the individuals' more immediate medical testing and treatment needs. One other case was due to the individual's medically problematic blood alcohol content, and another was due to the individual's mobility difficulties. The last case occurred as a result of hazardous road conditions during a snow storm. All of these individuals were ultimately admitted to the state psychiatric hospital. The five cases in March represent a 67% increase in the number of delayed admissions from February (February = 3, March =5). Graph 6a and table 6 displays this data by region in Appendix C, page 17, and shows that regions 2, 3, 4, and 7 did not experience this type of occurrence in March.



Graph 7. TDO executed after ECO expired statewide

Amendment added 1/12/2017)

Upon further analysis of the TDO Exception Reports issued September 2014 through June 2015, PPR7 and Blue Ridge Behavioral Healthcare, the CSB serving this region, initially reported time of issuance of the TDO versus execution of the TDO, which is the format that all other PPR regions used to calculate outcomes. This made the comparison between PPR&s data and other regions invalid. Please refer to the chart below for corrections to the data:

Month	ORIGINIALLY REPORTED # of incidents in which TDO was executed after the ECO expired in original report	CORRECTIONS TO DATA # of incidents in which TDO was obtained prior to the ECO expiring but not executed before the ECO expired
September 2014	25	3
October 2014	21	3
November 2014	18	3
December 2014	22	1

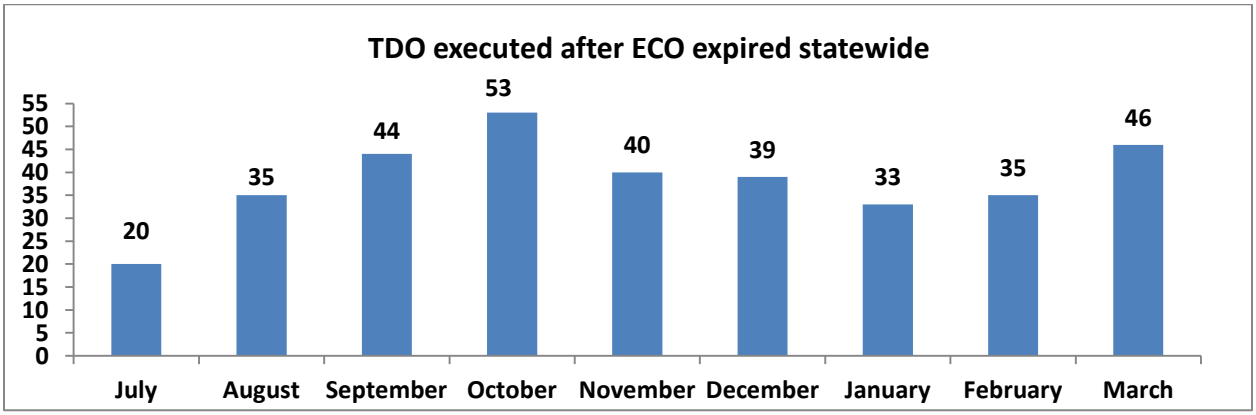
January 2015	20	6
February 2015	19	4
March 2015	23	1
April 2015	22	2
May 2015	37	5
June 2015	21	5

In March, there were 46 (2% of total) reported cases where a TDO was issued but not executed until after the ECO period had ended (Graph 7). This is a 31% increase from February, and the second highest monthly total in FY 2015. The majority of these cases (30 of 46) involved waiting for law enforcement to execute TDOs that were issued prior to the expiration of the ECO time period. In eight cases, law enforcement declined to execute the TDO until medical treatment was completed. One case involved an individual who needed a Medical TDO after the psychiatric TDO had already been issued but not executed. Two other cases were due to delayed access to a magistrate for TDO issuance; two more were due to difficulty accessing a bed in an appropriate facility; two others were the result of the CSB receiving late notification from law enforcement that an individual was under ECO; one was due to the TDO being incorrectly executed by hospital security personnel; and one was as a result of CSB staff error. The CSB that recorded the staff error has provided staff training for all emergency evaluators to prevent delay in the future. In 44 of these cases, the individuals were maintained safely in an emergency department, with law enforcement or security presence, and ultimately admitted to a psychiatric hospital without any lapse in custody. The remaining individuals were maintained safely within a medical unit of a hospital or a CIT Assessment Center. All of these individuals were safely admitted to a psychiatric hospital without any loss of custody except for one individual, reported above, who no longer needed psychiatric treatment following the resolution of a medical problem. Providers continue to use secure environments (such as locked emergency department or secure assessment sites) as well as law enforcement officers, to maintain custody.

Graph 7a and table 7 display this data by region in Appendix C, page 18. Regionally, frequency of these cases is highly variable. All regions had at least one event of this type during March, 2015.

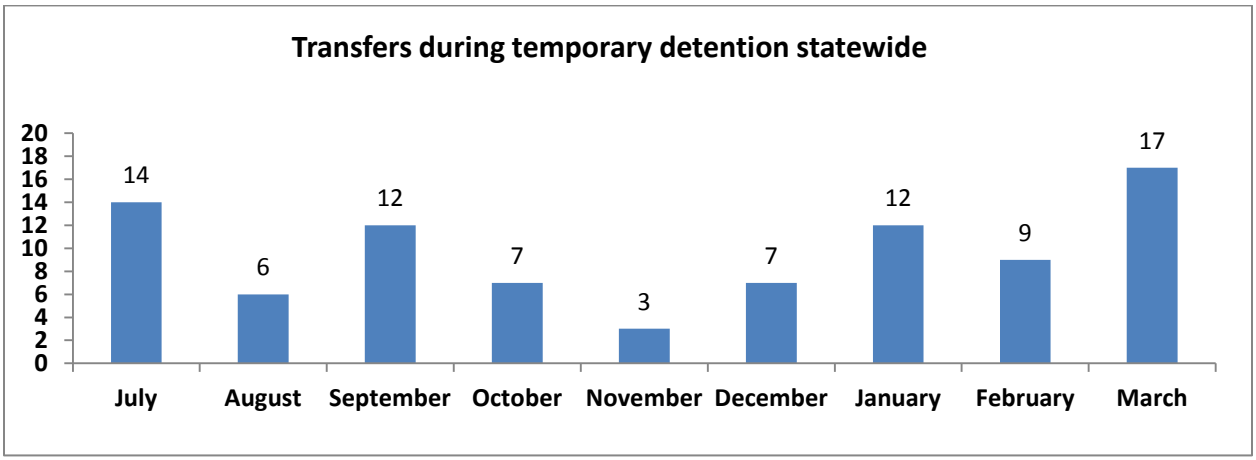
Region 7 continues to have a significantly greater number of these cases than any other region, and has had more of these events than all other regions combined since December. This region reported 116 TDOs issued and executed during March, 2015, with 23 (20%) executed after the ECO period expired. The time delay between issuance and execution of TDOs ranged from one hour and two minutes to 12 hours and 59 minutes with a mean of 4 hours and 8 minutes and a median of 2 hours and 26 minutes. Three of these cases involved individuals in custody waiting more than 12 hours before the TDO was executed. DBHDS Quality Oversight Team has maintained a continuous active focus on this region. Most recently, DBHDS Quality Oversight Team members attended a regional meeting with representation from local law enforcement, private facilities, the state facility, the magistrate and special justice, as well as Blue Ridge Behavioral Health (BRBH), the CSB serving the five metropolitan Roanoke area jurisdictions. The meeting was to plan the implementation of quality improvement strategies to reduce these delays. To date, the efforts continue to target Carillion Emergency and Police Departments, the Roanoke City Sheriff and Magistrate, and Catawba Hospital. DBHDS maintains continuous monitoring of this effort. A new procedure to take advantage of a 2015 statutory change designating the Carillion

Police as a law enforcement agency was planned for implementation on April 15, 2015. Specifically, by transmitting TDOs electronically from the magistrate to the Carillion Emergency Department, the Carillion Police will be able to execute these TDOs more rapidly following issuance. This new procedure, however, has not yet been implemented as promised. DBHDS and the local agencies are continuing to address these transactions intensively.



Graph 8. Transfers during temporary detention statewide

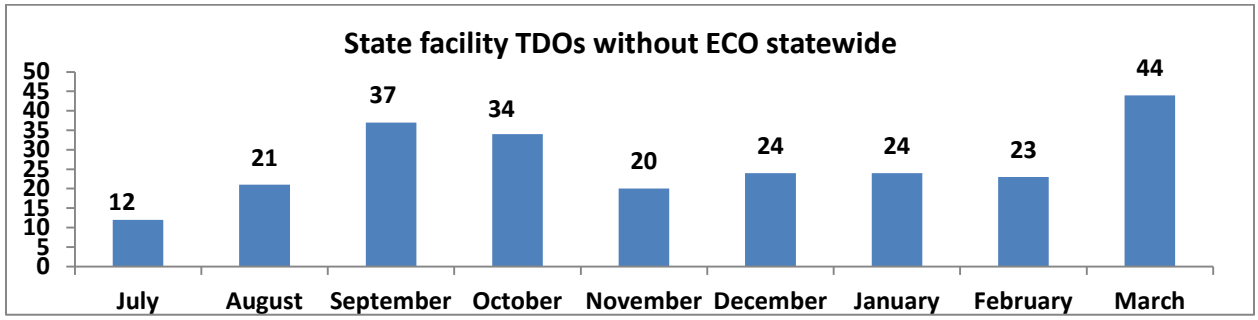
Section § 37.2-809.E. of the *Code of Virginia* allows an individual to be transferred during the period of detention from one temporary detention facility to another more appropriate facility in order to address an individual's security, medical or behavioral health needs. This procedure was used 17 times (<1%) during March (Graph 8). In twelve cases, the transfer was from a state facility. Ten of these were to a private psychiatric facility one was to a community based crisis residence, and one was to a private specialty facility. Two other transfers were from emergency departments to a state or private facility. One transfer was from a medical facility to a private facility; one transfer was from a private facility to a state facility; and one transfer was from a private facility to another private facility. Graph 8a and table 8 displays this data by region in Appendix C, page 19. Regions 3 and 6 did not report any of these transfers in March.



Virginia Department of Behavioral Health & Developmental Services

Graph 9. State hospital TDOs without ECOs statewide

As the hospital of "last resort", DBHDS facilities admit individuals who need temporary detention for whom no alternative placement can be found, whether or not the individual is under an ECO. CSBs report every "last resort" admission where no ECO preceded the admission, along with how many alternate facilities were contacted and the reason(s) for the inability to locate an alternate facility. In March, there were 44 such admissions to a state facility, a significant increase of 91% from February (Graph 9) and the highest monthly total of FY 2015 to date. A total of 395 contacts were made for an average of about nine alternate facilities contacted to secure these admissions. Sixteen of the admissions were for specialized care due to the individual's age (either minor or adult aged 65 and older) while eight others were due to lack of capacity of the alternate facilities contacted by the CSBs. Other reasons for these admissions were diagnosis of intellectual or developmental disability; medical needs beyond the capability of the alternate facilities contacted; and diagnosis of a traumatic brain injury. DBHDS monitors the Psychiatric Bed Registry daily for updating by facilities regarding their bed space capability as well as the comments entered by CSB clinicians who use the registry in seeking a bed. Graph 9a and table 9 displays this data by region in Appendix C, page 20. Region 7 did not report any TDOs to a state facility for individuals not subject to an ECO in March 2015.



Discussion:

To enhance consistency and accuracy of CSB reporting, DBHDS has worked continuously since July with individual CSBs and regions to ensure that data elements and reporting procedures are clearly understood and consistently reported. DBHDS and CSBs have established a workgroup consisting of CSB Executive Directors and DBHDS representatives that has developed a quality review framework to further strengthen the quality oversight processes and ensure that this data is consistently used by CSBs to identify trends and correct problems at the agency, regional, and statewide levels.

In addition to the above ongoing efforts, in FY 2016 DBHDS will be comparing TDO data collected through these monthly CSB reports with court data obtained through the court system to understand further how, and it what ways, existing reporting methods may influence the accuracy or variability of these data. Regional executive director forums will also review the reported data on a quarterly basis to examine trends and to review and strengthen regional quality improvement process.

These data enable DBHDS to conduct ongoing system monitoring and performance improvement efforts. As a result, DBHDS, CSBs, and local emergency service partners are communicating more regularly and timely to improve local care coordination, eliminating system gaps and clarifying agency and staff roles in the emergency response system. Lastly, DBHDS continues to convene regular and frequent stakeholder meetings at the state level to share this data, communicate directly about problem issues, and jointly develop and implement effective operational improvements.

APPENDIX A

Data Elements Reported Monthly by CSB/BHAs

Each CSB/BHA reports four data factors on volume to the region:

1. Emergency contacts: The total number of calls, cases, or events per month requiring any type of CSB emergency services involvement or intervention, whether or not it is about emergency evaluation, and regardless of disposition. Calls seeking information about emergency services, potential referrals, the CSB, etc., should be counted if the calls come to emergency services (e.g., through the crisis line) and require emergency services to respond. Any other contacts to emergency services from individuals, family members, other CSB staff, health providers or any other person or entity, including contacts that require documentation in an individual's health record, should be counted as emergency contacts. Any contacts that precipitate an intervention or emergency response of any kind should be counted as emergency contacts.
2. Emergency Evaluations: Emergency evaluations are clinical examinations of individuals that are performed by emergency services or other CSB staff on an emergency basis to determine the person's condition and circumstances, and to formulate a response or intervention if needed. This figure is the total number of emergency evaluations completed, regardless of the disposition, including evaluations conducted in person or by means of two-way electronic video/audio communication as authorized in 37.2-804.1.
3. Number of TDOs Issued: TDOs are issued by a magistrate.
4. Number of TDOs Executed: TDOs are executed by law enforcement officers. A TDO is executed when the individual is taken into custody by the law enforcement officer serving the temporary detention order. It is possible under some circumstances that a TDO issued by a magistrate may not be executed for some reason.

Each CSB/BHA also reports six additional data elements:

1. Cases where the state hospital was used as a “last resort”: Under the new statutory procedures effective July 1, 2014, when an individual is in emergency custody and needs temporary detention, and no other temporary detention facility can be found by the end of the 8-hour period of emergency custody, then the state hospital shall admit the individual for temporary detention. Each region's Regional Admission Protocol describes the process to be followed for accessing temporary detention facilities and for accessing the state hospital as a "last resort" facility for temporary detention.
2. Cases where a back-up state hospital was used: Under some circumstances, the primary state hospital may not be accessible as the "last resort" temporary detention facility when needed at the end of the 8-hour ECO period, and a back-up state hospital will need to admit the individual as a "last resort" admission.
3. Cases where the state hospital is called upon as the "last resort" for temporary detention, but admission cannot occur at the 8-hour expiration of the ECO because of a medical or related clinical issue that must be addressed (i.e., medical condition cannot be treated effectively in the state hospital, person is not medically stable for transfer to state hospital, required medical testing is not yet completed, etc.).
4. Cases where a TDO may be issued by a magistrate while the person is in emergency custody, but the TDO will not be executed until after the 8-hour period of emergency custody has expired. Under the new

statutes, if this scenario should occur, the individual may not be released from the CSB's custody until the TDO is executed.

5. Cases where a facility of temporary detention is transferred post-TDO: a CSB is allowed to change the facility of temporary detention for an individual at any time during the period of temporary detention pursuant to 37.2-809.E.
6. Cases where there is no ECO, but TDO to state hospital as a “last resort”: These are instances when an individual who is not in emergency custody (i.e., no ECO) is deemed to need temporary detention. If no suitable alternative facility can be found, state hospitals must serve as the "last resort" temporary detention facility in these cases.

Note: For the six data elements immediately above, associated descriptor information is reported as well.

APPENDIX B

Partnership Planning Region	Community Services Board or Regional Behavioral Health Authority
1 Northwestern Virginia	Horizon Behavioral Health Services Harrisonburg-Rockingham CSB Northwestern Community Services Rappahannock Area CSB Rappahannock-Rapidan CSB Region Ten CSB Rockbridge Area Community Services Valley CSB
2 Northern Virginia	Alexandria CSB Arlington County CSB Fairfax-Falls Church CSB Loudon County CSB Prince William County CSB
3 Southwestern Virginia	Cumberland Mountain CSB Dickenson County Behavioral Health Services Highlands Community Services Mount Rogers CSB New River Valley Community Services Planning District One Behavioral Health Services
4 Central Virginia	Chesterfield CSB Crossroads CSB District 19 CSB Goochland-Powhatan Community Services Hanover CSB Henrico Area Mental Health & Developmental Services Board Richmond Behavioral Health Authority
5 Eastern Virginia	Chesapeake CSB Colonial Behavioral Health Eastern Shore CSB Hampton-Newport News CSB Middle Peninsula-Northern Neck CSB Norfolk CSB Portsmouth Department of Behavioral Healthcare Services Virginia Beach CSB Western Tidewater CSB
6 Southern	Danville-Pittsylvania Community Services Piedmont Community Services Southside CSB
7 Catawba Region	Alleghany Highlands CSB Blue Ridge Behavioral Healthcare

APPENDIX C

Graph 1a. Emergency contacts by region

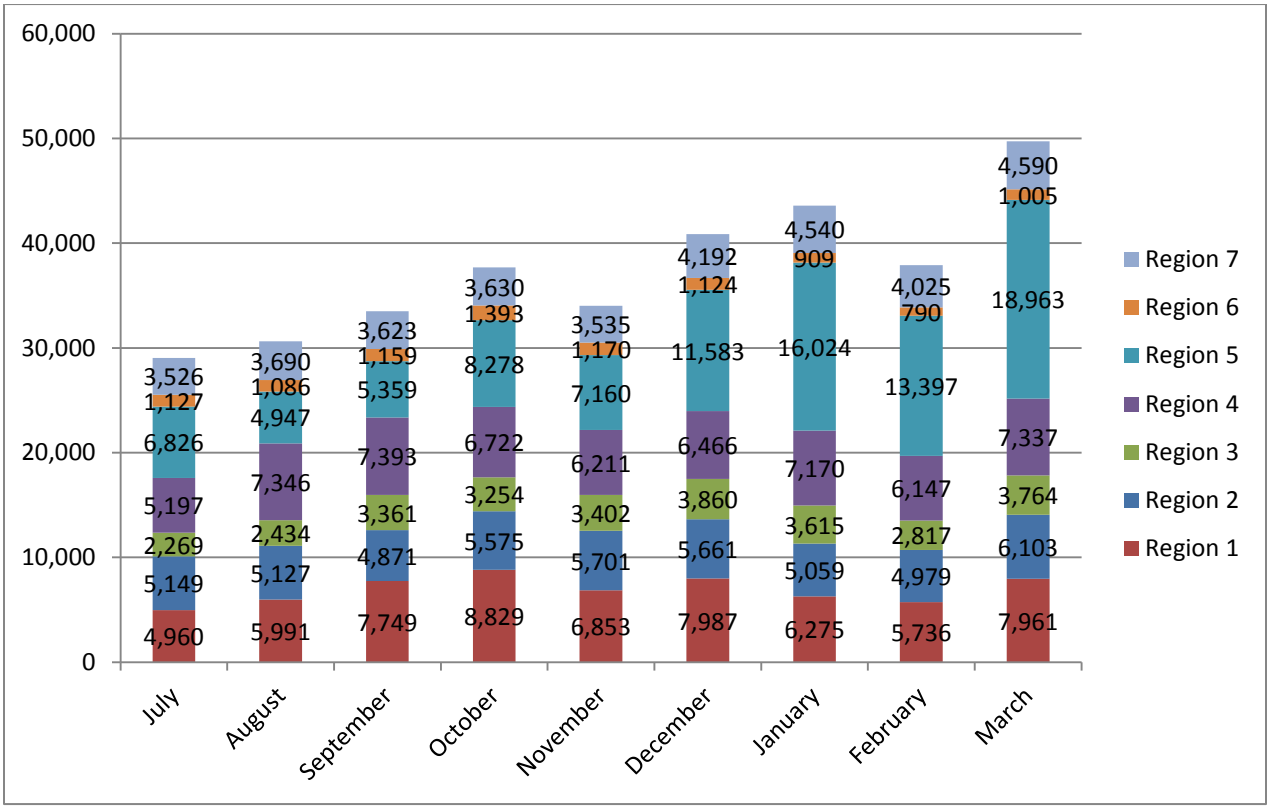


Table 1. Number of emergency contacts (corresponds with graph 1a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Region 1	4,960	5,991	7,749	8,829	6,853	7,987	6,275	**5,736**	7,961	**62,341**
Region 2	5,149	5,127	4,871	5,575	5,701	5,661	5,059	**4,979**	6,103	**48,225**
Region 3	2,269	2,434	3,361	3,254	3,402	3,860	3,615	**2,817**	3,764	**28,776**
Region 4	5,197	7,346	7,393	6,722	6,211	6,466	7,170	**6,147**	7,337	**59,989**
Region 5	6,826	4,947	5,359	8,278	7,160	11,583	16,024	**13,397**	18,963	**92,537**
Region 6	1,127	1,086	1,159	1,393	1,170	1,124	909	**790**	1,005	**9,763**
Region 7	3,526	3,690	3,623	3,630	3,535	4,192	4,540	**4,025**	4,590	**35,351**
Total	**29,054**	**30,621**	**33,515**	**37,681**	**34,032**	**40,873**	**43,592**	**37,891**	**49,723**	**336,982**

Graph 2a. Emergency evaluations by region

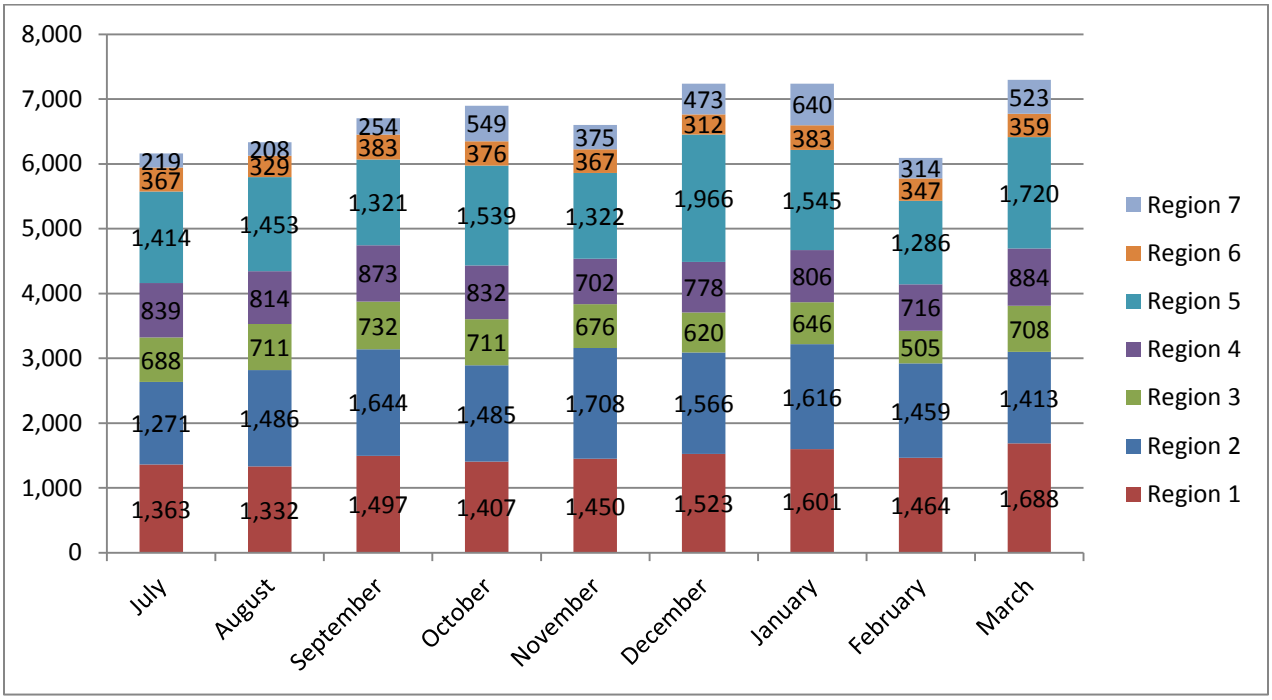


Table 2. Number of emergency evaluations (corresponds with graph 2a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Region 1	1,363	1,332	1,497	1,407	1,450	1,523	**1,601**	**1,464**	1,688	**13,325**
Region 2	1,271	1,486	1,644	1,485	1,708	1,566	**1,616**	**1,459**	1,413	**13,648**
Region 3	688	711	732	711	676	620	**646**	**505**	708	**5,997**
Region 4	839	814	873	832	702	778	**806**	**716**	884	**7,244**
Region 5	1,414	1,453	1,321	1,539	1,322	1,966	**1,545**	**1,286**	1,720	**13,566**
Region 6	367	329	383	376	367	312	**383**	**347**	359	**3,223**
Region 7	219	208	254	549	375	473	**640**	**314**	523	**3,555**
Total	**6,161**	**6,333**	**6,704**	**6,899**	**6,600**	**7,238**	**7,237**	**6,091**	**7,295**	**60,558**

Graph 3a. TDOs issued by region

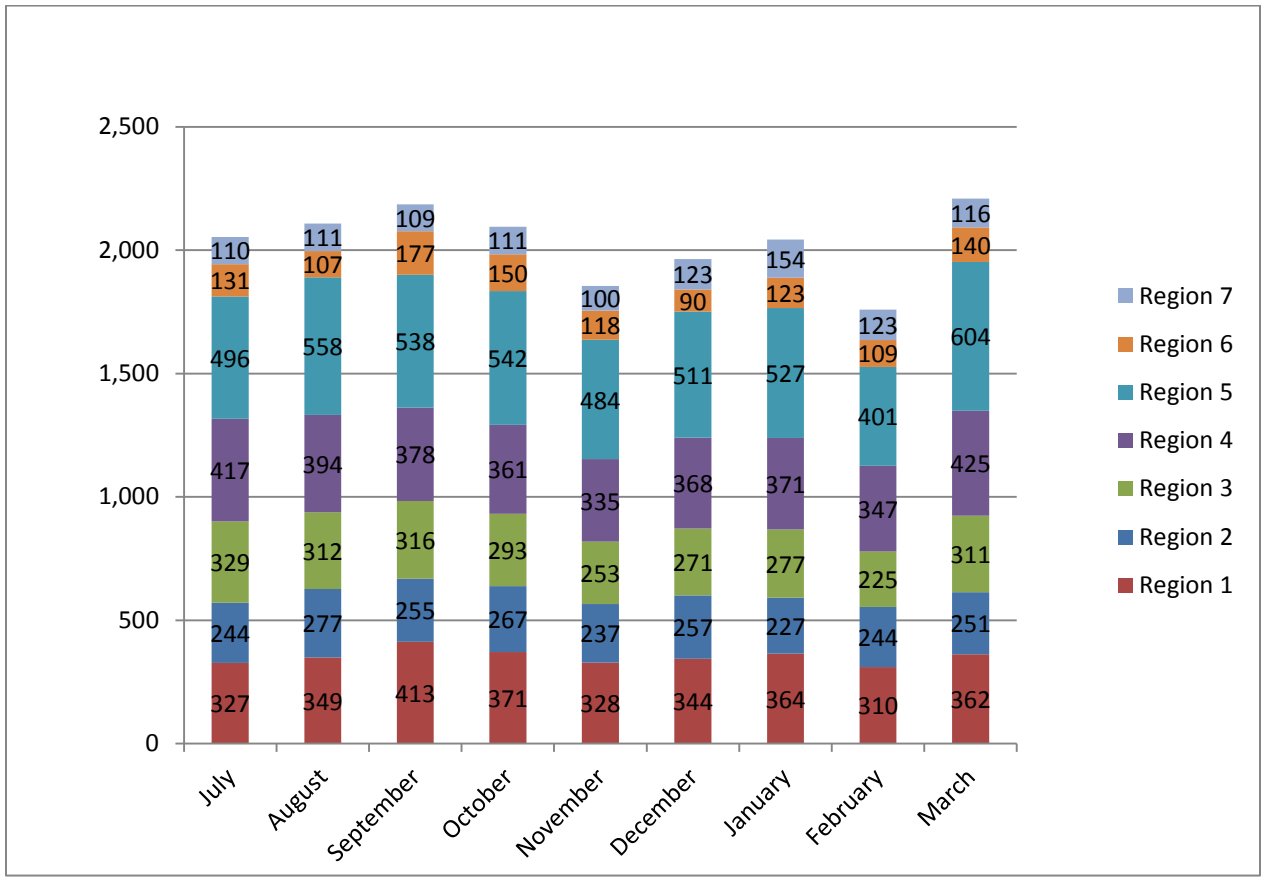


Table 3. Number of TDOs issued (corresponds with graph 3a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Region 1	327	349	413	371	328	344	**364**	**310**	362	**3,168**
Region 2	244	277	255	267	237	257	**227**	**244**	251	**2,259**
Region 3	329	312	316	293	253	271	**277**	**225**	311	**2,587**
Region 4	417	394	378	361	335	368	**371**	**347**	425	**3,396**
Region 5	496	558	538	542	484	511	**527**	**401**	604	**4,661**
Region 6	131	107	177	150	118	90	**123**	**109**	140	**1,145**
Region 7	110	111	109	111	100	123	**154**	**123**	116	**1,057**
Total	**2,054**	**2,108**	**2,186**	**2,095**	**1,855**	**1,964**	**2,043**	**1,759**	**2,209**	**18,273**

Graph 4a. TDOs executed by region

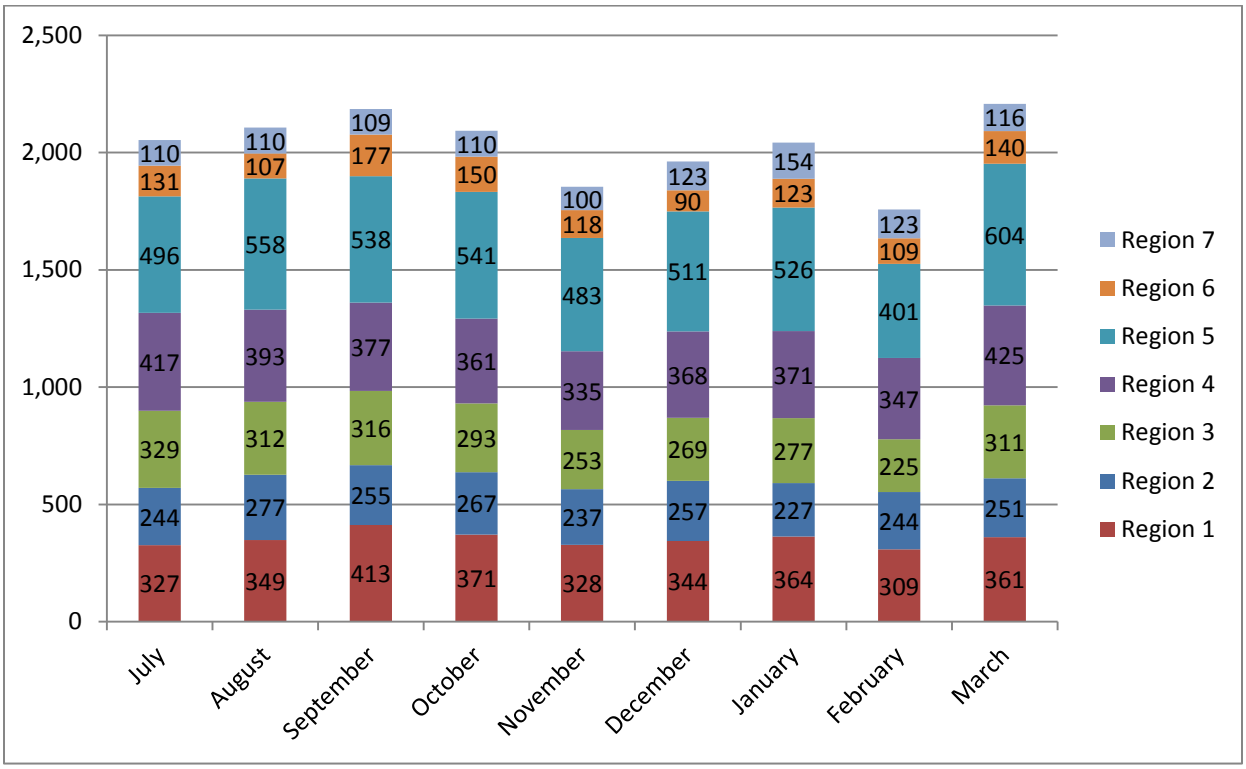


Table 4. Number of TDOs executed (corresponds with graph 4a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Region 1	327	349	413	371	328	344	**364**	**309**	361	**3,166**
Region 2	244	277	255	267	237	257	**227**	**244**	251	**2,259**
Region 3	329	312	316	293	253	269	**277**	**225**	311	**2,585**
Region 4	417	393	377	361	335	368	**371**	**347**	425	**3,394**
Region 5	496	558	538	541	483	511	**526**	**401**	604	**4,658**
Region 6	131	107	177	150	118	90	**123**	**109**	140	**1,145**
Region 7	110	110	109	110	100	123	**154**	**123**	116	**1,055**
Total	**2,054**	**2,106**	**2,185**	**2,093**	**1,854**	**1,962**	**2,042**	**1,758**	**2,208**	**18,262**

Graph 5a. TDO admissions to a state hospital by region

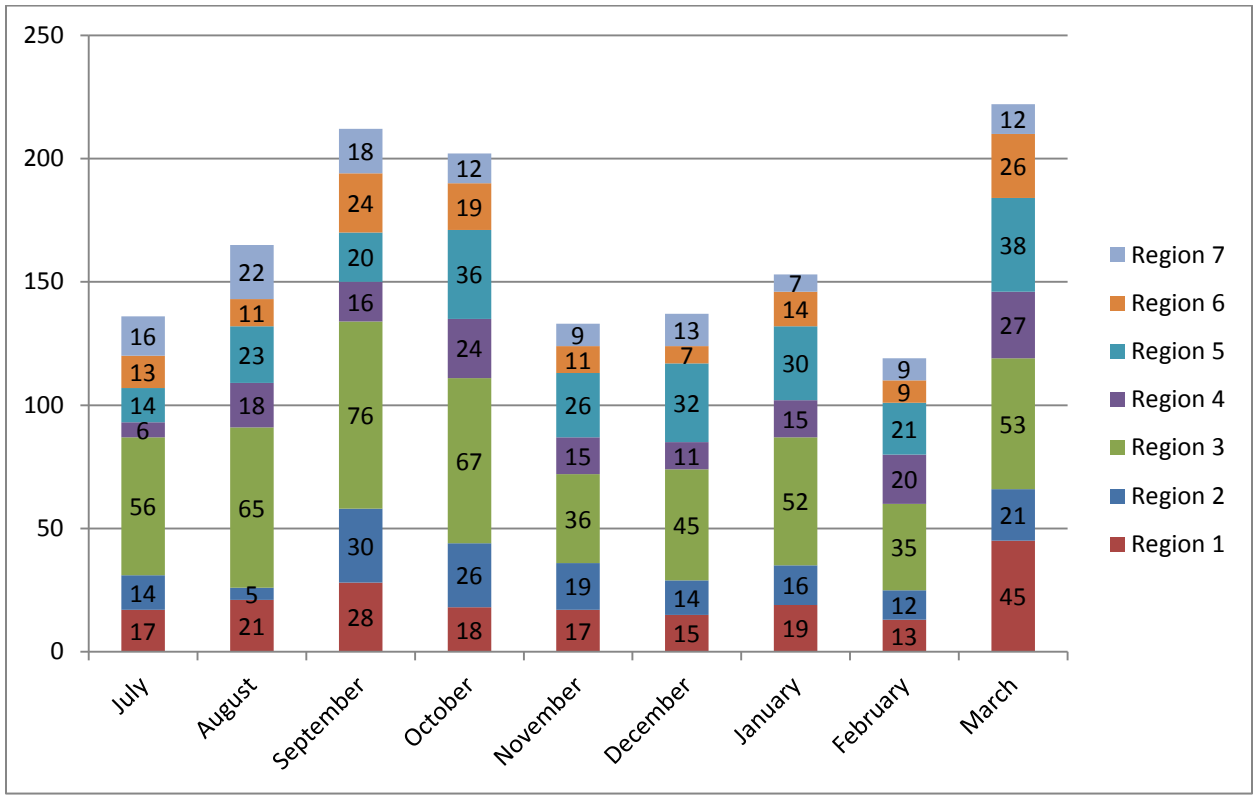


Table 5. TDO admissions to a state hospital (corresponds with graph 5a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Region 1	17	21	28	18	17	15	**19**	**13**	**45**	**193**
Region 2	14	5	30	26	19	14	**16**	**12**	**21**	**157**
Region 3	56	65	76	67	36	45	**52**	**35**	**53**	**485**
Region 4	6	18	16	24	15	11	**15**	**20**	**27**	**153**
Region 5	14	23	20	36	26	32	**30**	**21**	**38**	**240**
Region 6	13	11	24	19	11	7	**14**	**9**	**26**	**135**
Region 7	16	22	18	12	9	13	**7**	**9**	**12**	**118**
Total	**136**	**165**	**212**	**202**	**133**	**137**	**153**	**119**	**222**	**1,479**

Graph 6a. State hospital admission delayed by region

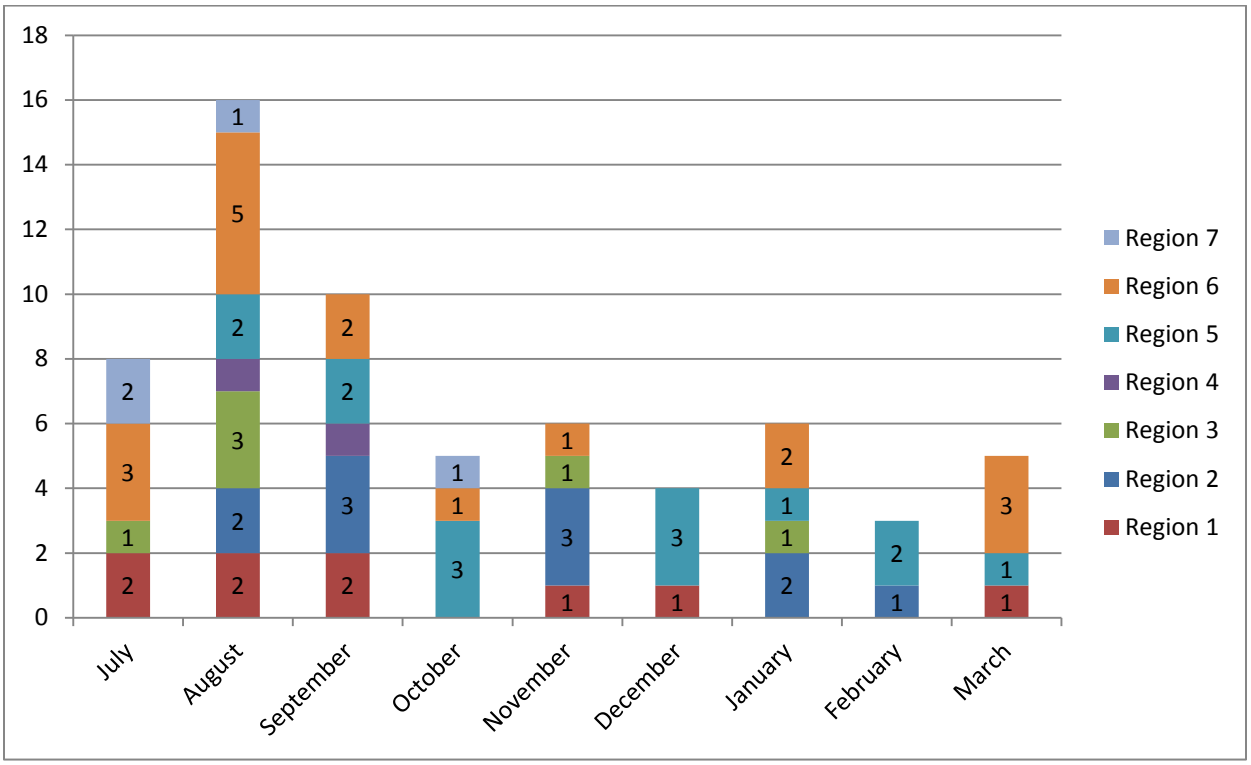


Table 6. State hospital admission delayed (corresponds with graph 6a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Region 1	2	2	2	0	1	1	**0**	**0**	1	**9**
Region 2	0	2	3	0	3	0	**2**	**1**	0	**11**
Region 3	1	3	0	0	1	0	**1**	**0**	0	**6**
Region 4	0	1	1	0	0	0	**0**	**0**	0	**2**
Region 5	0	2	2	3	0	3	**1**	**2**	1	**14**
Region 6	3	5	2	1	1	0	**2**	**0**	3	**17**
Region 7	2	1	0	1	0	0	**0**	**0**	0	**4**
Total	**8**	**16**	10	**5**	**6**	**4**	**6**	**3**	**5**	**63**

Graph 7a. TDO executed after ECO expired by region

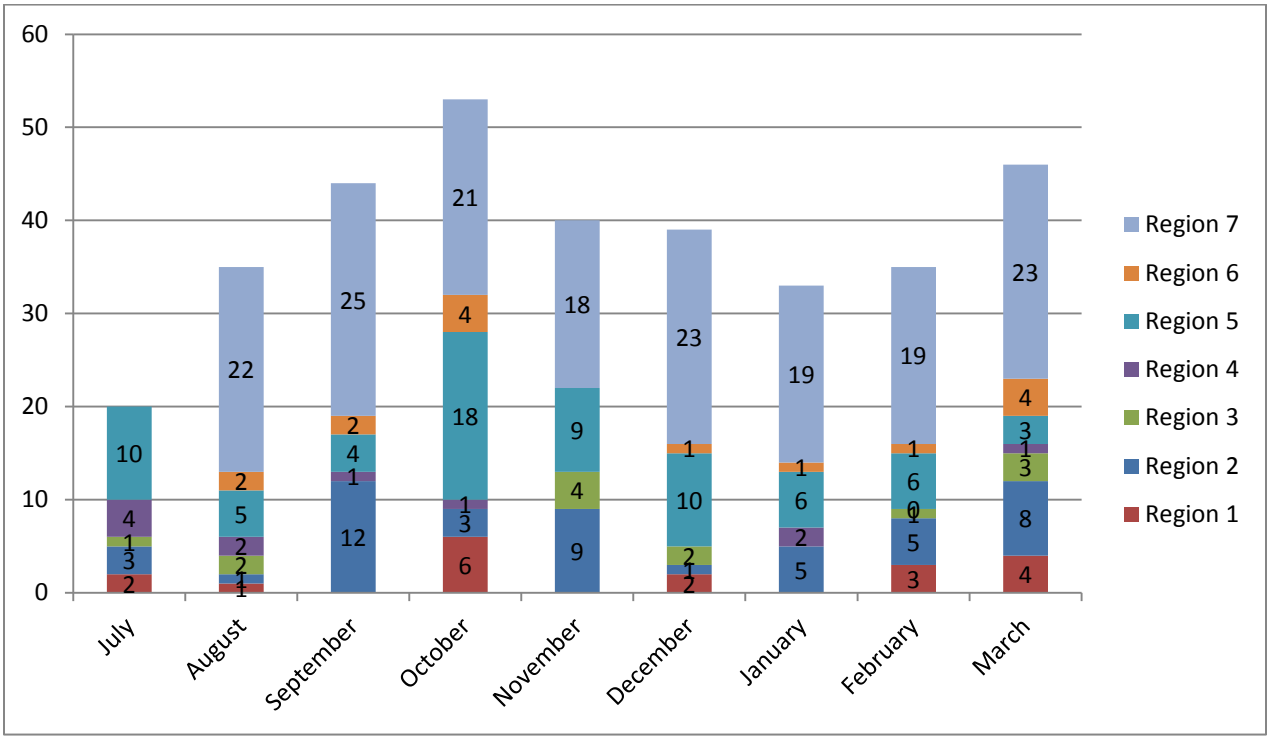


Table 7. TDO executed after ECO expired (corresponds with graph 7a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Region 1	2	1	0	6	0	2	**0**	**3**	4	**18**
Region 2	3	1	12	3	9	1	**5**	**5**	8	**51**
Region 3	1	2	0	0	4	2	**0**	**1**	3	**13**
Region 4	4	2	1	1	0	0	**2**	**0**	1	**11**
Region 5	10	5	4	18	9	10	**6**	**6**	3	**71**
Region 6	0	2	2	4	0	1	**1**	**1**	4	**15**
Region 7	0	22	25	21	18	23	**19**	**19**	23	**170**
Total	**20**	**35**	44	**53**	**40**	**39**	**33**	**35**	**46**	**345**

Graph 8a. Transfers during temporary detention by region

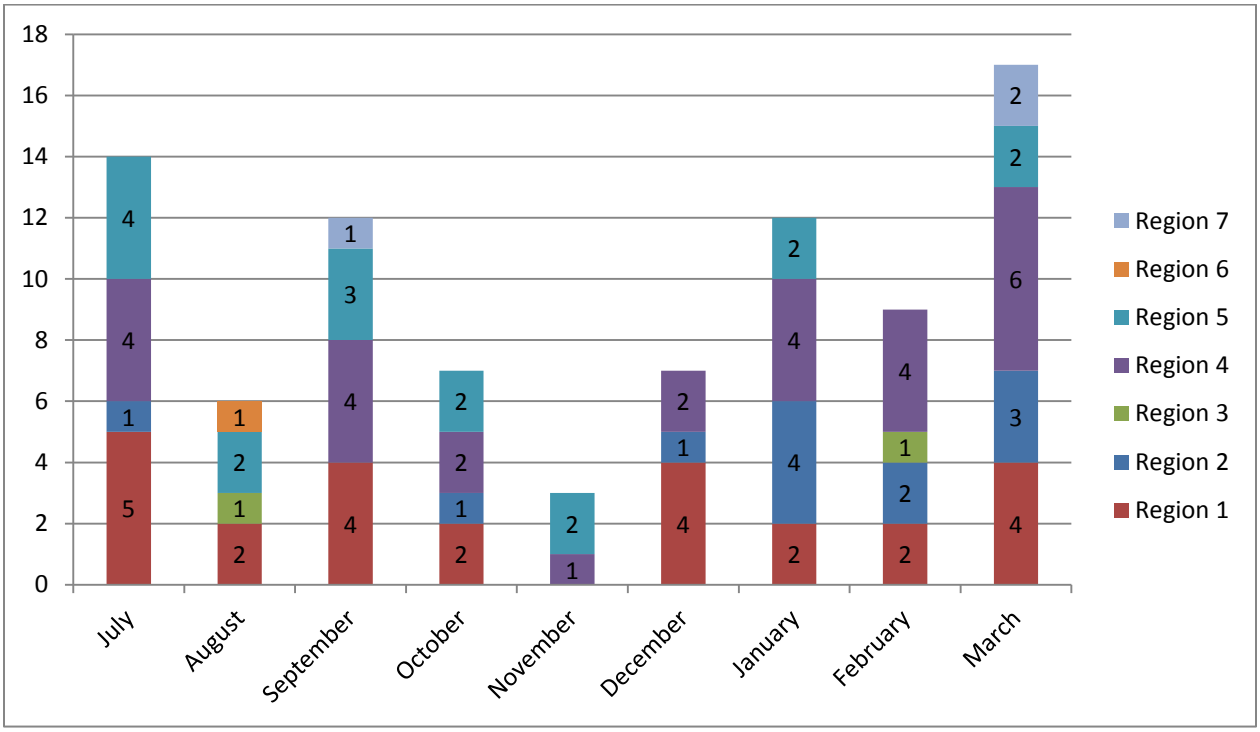


Table 8. Transfers during temporary detention (corresponds with graph 8a, pg 10)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Region 1	5	2	4	2	0	4	**2**	**2**	4	**25**
Region 2	1	0	0	1	0	1	**4**	**2**	3	**15**
Region 3	0	1	0	0	0	0	**0**	**1**	0	**2**
Region 4	4	0	4	2	1	2	**4**	**4**	6	**28**
Region 5	4	2	3	2	2	0	**2**	**0**	2	**17**
Region 6	0	1	0	0	0	0	**0**	**0**	0	**1**
Region 7	0	0	1	0	0	0	**0**	**0**	2	**3**
Total	**14**	**6**	**12**	**7**	**3**	**7**	**12**	**9**	**17**	**87**

Graph 9a. TDOs to state hospital without ECO by region

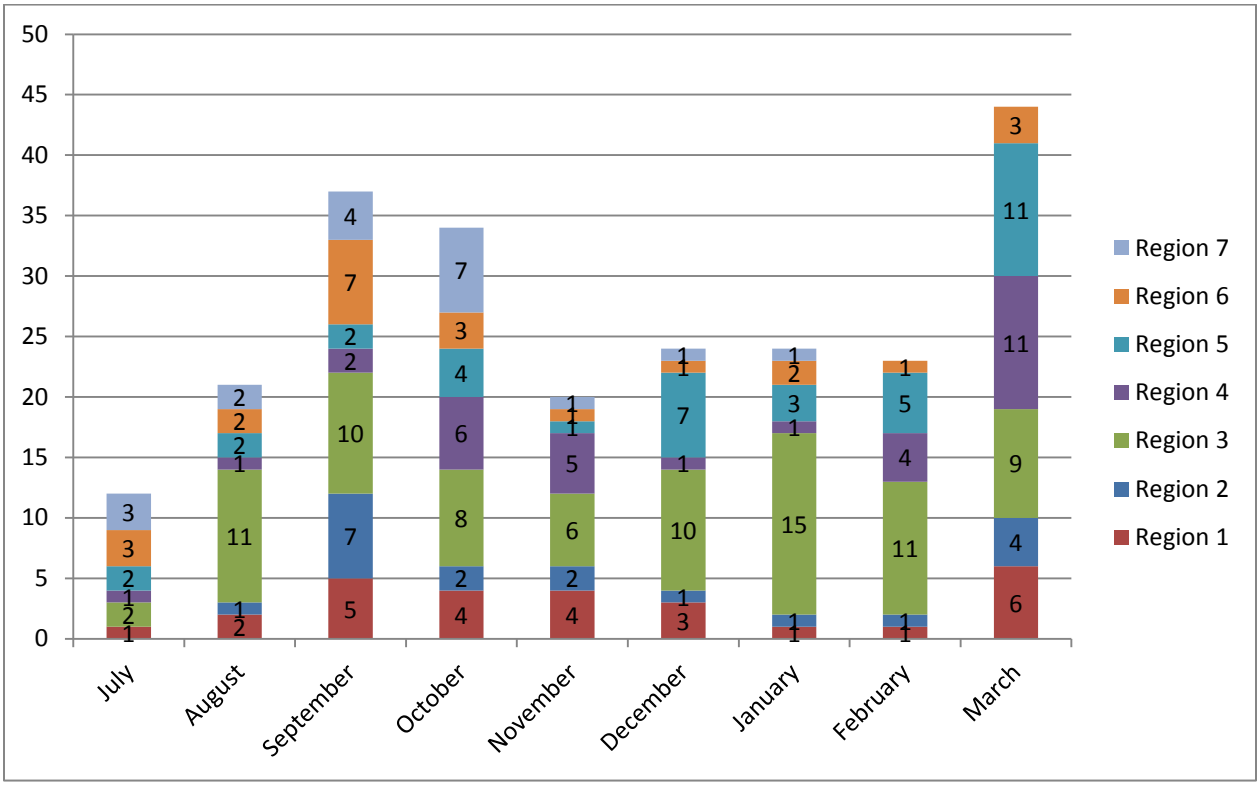


Table 9. State hospital TDOs without ECOs (corresponds with graph 9a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Region 1	1	2	5	4	4	3	**1**	**1**	6	**26**
Region 2	0	1	7	2	2	1	**1**	**1**	4	**19**
Region 3	2	11	10	8	6	10	**15**	**11**	9	**82**
Region 4	1	1	2	6	5	1	**1**	**4**	11	**35**
Region 5	2	2	2	4	1	7	**3**	**5**	11	**37**
Region 6	3	2	7	3	1	1	**2**	**1**	3	**24**
Region 7	3	2	4	7	1	1	**1**	**0**	0	**18**
Total	**12**	**21**	**37**	**34**	**20**	**24**	**24**	**23**	**44**	**239**

APPENDIX D

DBHDS requires CSBs to report within 24-hours any event involving an individual who has been determined to require temporary detention for whom the TDO is not executed for any reason, whether or not an ECO was issued or in effect. These reports are sent to a DBHDS Quality Oversight team that includes the DBHDS Medical Director, the Assistant Commissioner for Behavioral Health, the Director of Community Behavioral Health Services, the Director of Mental Health Services, and the MH Crisis Specialist. Each report contains the CSB's description of the incident and the CSB's proposed actions to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality Oversight team examines the report for completeness and comprehensiveness, and responds immediately to the CSB Executive Director if any further information is needed. In addition, DBHDS specifies additional necessary follow up actions, and requests appropriate follow up communication from the CSB. DBHDS maintains an open incident file until the incident has resolved and all follow up actions are completed.

There were nine such events during the month of March, 2015. Four of these cases involved individuals who were in emergency custody when evaluated, and five cases involved individuals who were not under an ECO. Of the nine cases, five individuals eloped from the evaluation site before the TDO was executed. Seven of these individuals were ultimately hospitalized, and in the other two cases the CSB was not able to establish any treatment relationship with the individual after exhausting all options to do so. The nine reported cases are summarized below.

DBHDS has followed up with the relevant CSB in each of these events to gather additional information and to give the CSB specific clinical and quality feedback about how each case was handled, what behaviors or procedures may have contributed to the event, what clinical and administrative or process issues need to be addressed in developing solutions to the problems encountered, strategies to implement with partner entities, and etc. These case-driven DBHDS interventions are ongoing.

1. This individual was in a hospital emergency department (ED) with a partner who was seeking medical treatment. The couple was asked to leave the ED after they began to argue. When the partner returned to the ED, the individual followed, and was once again asked to leave the premises by hospital security. When the individual refused to leave, the hospital security called the local police for assistance. When the police arrived, the individual remained agitated and requested that the police shoot him. Police took custody of the individual under a paperless ECO and notified the CSB of the need for evaluation. The individual was evaluated and found to meet criteria for inpatient psychiatric care. The individual had informed the evaluator that he was a veteran and was willing to seek voluntary treatment. With that information, the ED staff began making arrangements for admission to the closest Veteran's Administration Hospital in the adjacent state. Because the individual was willing and capable of consenting to voluntary treatment, the police and the CSB emergency evaluator left the emergency department. Subsequently, the individual left the ED against medical advice (AMA).

   The CSB was immediately notified, and the CSB evaluator obtained a paper ECO based on findings from the earlier evaluation. Law enforcement was notified and began a search for the individual, but did not

locate him prior to the ECO expiration. Approximately 10 hours later, the CSB supervisor learned that the individual had still not been located when police contacted the CSB requesting an update on the case,. Further discussion with local law enforcement revealed that a state trooper from the neighboring state had stopped the individual in his car as a result of the bulletin issued by Virginia police. The individual informed the trooper that he had been to the VA Hospital and received treatment. The trooper did not attempt to take the individual into custody and did not notify the Virginia police about this contact until later, after the ECO in Virginia had expired. A captain of the local Virginia police department informed the CSB that he had also spoken with the individual later in the morning and believed that the individual did not need further treatment. The police captain had also assured the individual that he would not be taken into custody at that point. The individual reported to the captain that, after leaving the ED, he had made his way through the woods to his home, and then had gone to the VA Hospital where he was given medication. The police captain informed the individual that he could retrieve his wallet and other possessions from the local hospital ED where he had left them. The CSB attempted to secure another ECO from the local magistrate but the petition was denied.

The DBHDS Quality Oversight Team reviewed the event and made further inquiries about safety management procedures in the ED, and about the collaboration between the CSB and local law enforcement and magistrates. The CSB attempted to engage the individual in care after the events described above, but the individual had no phone and could not be directly reached. His collateral contacts were given information on how to access emergency help but otherwise were not interested in securing help from the CSB for this individual, and ultimately, the individual was not served by the CSB. The CSB and the hospital ED met to review and strengthen internal procedures and practices for maintaining individuals safely in the hospital. At the request of DBHDS, the CSB also made contact with the local police department to discuss their involvement in this event. The CSB addressed the issue of officers making mental health determinations rather than individuals trained in mental health assessment. The CIT coordinator at the CSB has continued to work with the local police regarding collaboration with the CSB.

2. The CSB received a call from a local dispatcher requesting a preadmission screening for an individual in a local hospital ED. The CSB evaluator called the ED and learned that the individual was receiving medical care and was in the custody of an officer under an officer initiated ECO. The evaluator spoke directly with the officer, but the officer was unsure of the time the ECO began. The evaluator later learned the ECO had expired approximately 45 minutes prior to the initial notification from dispatch. The evaluator conducted the emergency evaluation and the individual was hospitalized under a TDO with no lapse in custody.

   The DBHDS Quality review team recommended that the CSB meet directly with the local law enforcement agency to review Code requirements regarding notification to the CSB. The CSB also met with the local hospital ED staff and distributed copies of the written notification requirements for individuals under an ECO.

3. An emergency evaluation was requested by a local hospital for an individual who was admitted to their Coronary Care Unit (CCU). The individual had agreed to remain on the unit for the assessment and cooperated with the evaluation process. The individual was found to meet TDO criteria. The evaluator left the unit and sought a TDO. Bed availability was confirmed at the same hospital in which the individual was currently receiving care. The individual had repeatedly asked to leave the unit and was being monitored by a nurse who was also responsible for another patient's medical needs. When the nurse went to care for the other patient, a curtain was pulled blocking a direct line of observation on the individual awaiting the TDO. At that point, the individual eloped from the unit by leaving unobserved through an emergency exit. The CCU staff notified local law enforcement and the hospital security for assistance with locating the individual. The police subsequently confirmed the individual had been admitted to a hospital for medical care in a neighboring state.

   The DBHDS Quality Oversight Team reviewed the event and recommended that the CSB follow up with the local hospital regarding procedures for individuals who meet criteria for a TDO. The CSB continued to seek information on the individual from the admitting hospital in the neighboring state until it was determined the individual was medically stable and able to be transferred to behavioral health services within that facility. The CSB requested and participated in a Root Cause Analysis with the local hospital to strengthen the hospital's approach to managing individuals with both medical and behavioral health needs.

4. While an individual was in a local hospital ED, the individual was assessed and found to meet TDO criteria. The individual became increasingly agitated during the evaluation. While the CSB evaluator was locating a temporary detention bed, the individual began asking to have his clothes and other belongings returned to him. The hospital security force was contacted for assistance. Security arrived to the room and with the assistance of a nurse and tried to discourage the individual from leaving the ED. A TDO was obtained, but before the order could be executed, hospital staff informed the evaluator that the individual had walked out of the ED and the security officer was following him. The evaluator went outside to assist with locating the individual while phoning local law enforcement. Hospital security returned to the ED reporting the individual had eloped by getting into a truck with his son. The evaluator notified dispatch of this information and provided known names and addresses of family member contacts for the individual. A description of the vehicle was provided to the police by hospital security. Multiple attempts to locate the individual through family members were made with no success. On one attempt the individual answered the phone and the CSB staff member was able to provide this information to the local law enforcement that was dispatched to the location and the individual was taken into custody.

   DBHDS Quality Oversight team reviewed the reported event and suggested the CSB investigate hospital security practices regarding situations such as this. The CSB determined that the hospital protocol prohibits their security force from using physical force to maintain custody of an individual until proof of the TDO is obtained. A copy of the order was not received in the ED prior to the individual's departure. The CSB reported to DBHDS their continued efforts to engage the medical facility in discussions on improving the safety of individuals within their emergency department.

5. This individual was seen for an emergency evaluation while under a paperless ECO in a hospital ED. The individual was assessed and determined to meet TDO criteria. The TDO was issued but not yet executed when the attending physician determined the individual had a prevailing medical condition which warranted a medical admission. The CSB maintained contact with the medical unit regarding the individual's condition and when the individual was ready for discharge a TDO was issued and executed. There was no loss of custody of this individual.

   DBHDS Quality Review Team reviewed the event and supported the actions taken by the CSB to maintain the safety of the individual while receiving medically necessary care.

6. This individual was assessed at a residential crisis stabilization unit and was found to meet criteria for a TDO. The individual was not under an ECO at the time of the evaluation. While the emergency evaluator was preparing the preadmission screening report, the individual eloped from the facility. Local law enforcement was notified and given a description of the individual. The individual appeared voluntarily at a local psychiatric facility about 6 hours later. The facility assessed the individual and contacted 911 to transport the individual to a local ED for medical treatment. While being treated for a self-inflicted injury, the individual's lab work revealed a recent ingestion of pills. The CSB was contacted to obtain a TDO. The TDO was issued allowing for medical care to continue until such time that it was medically safe to discharge. The individual was then detained in a psychiatric facility upon medical discharge.

   The DBHDS Quality Review Team reviewed the event focusing on the evaluation process and the crisis stabilization unit's arrangements for protecting the individual while waiting for the TDO to be executed. In this case, the CSB evaluator had advised the individual that inpatient hospitalization was recommended, and when the individual declined voluntary admission, the evaluator notified the individual a TDO would be sought. The individual was placed on a one-to-one status at the crisis stabilization unit and was verbally encouraged to stay by the unit staff but walked out the door of the unlocked unit. The police were immediately contacted by the crisis stabilization staff. DBHDS supported the decision to use a two stop TDO as it provided for the safest outcome for the individual to receive both the necessary medical and behavioral health treatment.

7. This individual had been brought to a hospital ED by his family. The emergency evaluation was completed and a decision was made to seek a TDO. The emergency evaluator was unable to locate a willing psychiatric hospital in the home community but found a hospital outside the area. The individual's family did not agree to this placement but were willing to wait in the ED with the individual until a local bed was available the following morning. The emergency room physician agreed with the plan.

   During the DBHDS Quality Review Team's review of this event, the CSB reported its decision to delay the admission was based on the individual's willingness to be admitted to the local hospital, an assessment that the individual presented little risk of eloping from the ED, the family's willingness to remain with the individual until a local bed was available, and the ED physician's support of this plan. The CSB's review of these actions found support for the decisions that were made by the evaluator.

8. This individual was assessed voluntarily in a local hospital ED where he had come with medical complaints. The individual voiced suicidal statements and an emergency evaluation was requested. The CSB was contacted to conduct the evaluation. The individual attempted to leave the ED, so local law enforcement was contacted to assist with maintaining custody of the individual and the evaluator obtained an ECO. The individual left the emergency department prior to law enforcement arriving on the scene. The evaluator provided a description of the individual to dispatch. The individual was returned to the ED by law enforcement within minutes, but the evaluation was postponed because the individual needed immediate medical treatment. The CSB remained in contact with the medical facility and re-assessed the individual the following day after medical treatment was completed. The individual met criteria for a TDO and the order was executed.

   DBHDS Quality Review Team reviewed the event and provided feedback to the CSB. It appears all systems operated effectively to protect the individual and to obtain the appropriate treatment.

9. This individual was seen in a community hospital ED on a paperless ECO following discharge earlier that day from a state hospital. The individual was evaluated and determined to meet TDO criteria but no private bed could be found for admission. The state hospital, CCCA, was over census and requested that the ED hold the individual until the following morning until a discharge would create a bed space for the individual. Initially, the ED physician agreed to allow the individual to be maintained in the ED until the next day when a bed could be secured. However, the physician later arranged for the individual to be transported by ambulance across state lines without the evaluator's knowledge. The family consented to this arrangement and the CSB was notified after the arrangements for transfer were made. The CSB continued to maintain contact with the receiving facility to ensure the individual's admission there. The individual was maintained in the out of state facility until the next day when a prearranged residential placement occurred in Virginia. The CSB reports this individual has been actively engaged in a range of services through the CSB and will continued to receive these services as deemed medically appropriate.

   DBHDS Quality Review Team reviewed the event. The CSB had contact with the state facility director to review the case, including the discharge, and it was determined the facility director should have been involved prior to the transfer out of state. The CSB provided education to the ED administrator on the complications of having the individual transferred across state lines and the need to collaborate with the emergency evaluator in these situations prior to action. DBHDS contracted with a private hospital to provide overflow capacity for CCCA so that CCCA can consistently provide timely access to a safety net bed.

All of these incidents were reported to DBHDS in accordance with the established protocol within 24 hours. As described above, in response to these cases, DBHDS and CSBs initiated targeted interventions with the individuals involved, and remedial efforts with service delivery partners to mitigate risks and improve processes and care coordination. DBHDS is monitoring these cases and actively working with regions and CSBs to identify and address factors contributing to the problems described in this TDO exceptions report.